UNITED STATES BANKRUPTCY COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

In re:

City of Detroit, Michigan,

Debtor.

_____/

Bankruptcy Case No. 13-53846
Honorable Thomas J. Tucker
Chapter 9

EXHIBIT D (BLUE CROSS PLAN) IN SUPPORT OF DPLSA'S RESPONSE IN OPPOSITION TO CITY OF DETROIT'S MOTION FOR (I) DETERMINATION THAT THE DETROIT POLICE LIEUTENANTS AND SERGEANTS ASSOCIATION HAS VIOLATED THE TERMS OF THE CITY OF DETROIT'S CONFIRMED PLAN OF ADJUSTMENT AND THE ORDER CONFIRMING IT; AND (II) ORDER (A) ENJOINING FURTHER VIOLATIONS AND (B) REQUIRING DISMISSAL OF STATE ACTIONS [DOCKET NO. 9656]

PART 1 OF 14

COMMUNITY BLUE GROUP BENEFITS CERTIFICATE ASC

(Available to ASC Accounts Only)

Dear Subscriber:

We are pleased you have selected Blue Cross Blue Shield of Michigan for your health care coverage. Your coverage provides many benefits for you and your eligible dependents. These benefits are described in this book, which is your **certificate**.

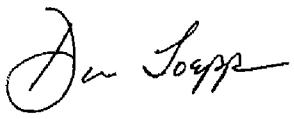
Your certificate, your signed application and your BCBSM identification card are your **contract** with us.

You may also have **riders**. Riders make changes to your certificate and are an important part of your coverage. When you receive riders, keep them with this book.

This certificate will help you understand your benefits and each of our responsibilities **before** you require services. Please read it carefully. If you have any questions about your coverage, call us at one of the BCBSM customer service telephone numbers listed in the "How to Reach Us" section of this book.

Thank you for choosing Blue Cross Blue Shield of Michigan. We are dedicated to giving you the finest service and look forward to serving you for many years.

Sincerely,



Daniel J. Loepp
President and Chief Executive Officer
Blue Cross Blue Shield of Michigan

About Your Certificate

This certificate is arranged to help you locate information easily. You will find:

- A **Table of Contents** — for quick reference
- **Information About Your Contract**
- **What You Must Pay**
- **What BCBSM Pays For**
- **General Services We Do Not Pay For**
- **How Providers Are Paid**
- **General Services We Do Not Pay For**
- **General Conditions of Your Contract**
- **Definitions — explanations of the terms used in your certificate**
- **Other Information You Should Know About Your Coverage**
- **How to Reach Us**
- **Index**

This certificate provides you with the information you need to get the most from your BCBSM health care coverage. Please call us if you have any questions.

Table of Contents

Section 1: Information About Your Contract

This section provides answers to general questions you may have about your contract. Topics include:

- **ELIGIBILITY**
  - Who is Eligible to Receive Benefits
  - End Stage Renal Disease (ESRD)
- **CANCELLATION**
  - How to Cancel Coverage
  - Cancellation
  - Rescission
- **CONTINUATION OF BENEFITS**
  - When You are Totally Disabled
  - Consolidated Omnibus Budget Reconciliation Act (COBRA)
  - Individual Coverage

ELIGIBILITY

Who is Eligible to Receive Benefits

You, your spouse (this does not include a person who marries a member who has coverage as a surviving spouse) and your children listed on your contract are eligible. You will need to complete an application for coverage.

BCBSM will review your application for coverage to determine if you, your spouse and your dependents are eligible for coverage. This determination is based upon the terms of your benefit plan, which include this certificate and any underwriting policies that are in effect at the time of your application.

If you, your group or someone applying for coverage on your behalf commits fraud or makes an intentional misrepresentation of material fact in completing the application, your coverage may be rescinded as described on Page 6, under "Rescission."

Children are covered through the end of the calendar year in which they turn 26 years of age if, and as long as, the subscriber continues to be covered under this certificate and the children are related to you by birth, marriage, legal adoption or legal guardianship.

Your child's spouse and your grandchildren are not covered under this certificate.

Disabled, unmarried children may remain on your contract beyond the end of the calendar year in which they turn age 26 if all of the following apply:

- They are diagnosed as totally and permanently disabled due to a physical disability or developmental disability and are incapable of supporting themselves.
- They are dependent on you for support and maintenance.

Physician certification, verifying the child's physical disability or developmental disability must be submitted to us no later than 31 days after the end of the calendar year in which the child turns age 26. The information will be evaluated to determine if the dependent meets this definition.

You may also request group coverage for yourself or your dependents within 60 days of the following event:

- Your Medicaid coverage or your dependents' CHIP coverage (Children's Health Insurance Program) is terminated due to loss of eligibility.

Who is Eligible to Receive Benefits (continued)

You must notify your group if there is a change in your family such as birth, divorce, death, etc. We must receive notice from your group within 30 days of when a dependent is removed from your contract and within 31 days of when a dependent is added. Contract changes take effect as of the date of the event. Any change in rates resulting from contract changes will take effect as of the effective date of the contract change.

If a dependent becomes ineligible for coverage under your contract, as in the case of a divorce, the dependent may be eligible for his or her own contract.

End Stage Renal Disease (ESRD)

We will coordinate our payment with Medicare for all covered services used by members with ESRD, including hemodialysis and peritoneal dialysis. Therefore, it is important that members with ESRD file a valid application for Medicare with the Social Security Administration. Dialysis services must be provided in a hospital, an in-network or participating freestanding ESRD facility or in the home.

When Medicare Coverage Begins

For members with ESRD, Medicare coverage begins the first day of the fourth month of dialysis, provided you file a valid application for Medicare with the Social Security Administration.

Dialysis begins February 12. Medicare coverage begins May 1.

The period before Medicare coverage begins (up to three months) is the Medicare waiting period.

If you begin a self-dialysis training program in the first three months of your regular course of dialysis, the Medicare waiting period is waived. In this case, Medicare coverage begins on the first day of the month in which you begin your regular course of dialysis.

If you are admitted to a Medicare-approved hospital for a kidney transplant or for related health care services you need prior to a transplant, Medicare coverage begins on the first day of the month in which you are admitted to the hospital. Your transplant must take place that month or within the following two months.

If your transplant is delayed more than two months after you are admitted to the hospital for the transplant or for related health care services you need prior to the transplant, Medicare coverage begins two months before the month of your transplant.

When BCBSM Coverage is the Primary or Secondary Plan

If your BCBSM group coverage is provided through an employer and you are entitled to Medicare because you have ESRD, your BCBSM coverage is your primary plan for all covered services for up to 33 months, which includes the three-month (maximum) waiting period and the 30-month coordination period. (A medical evidence report may be used to establish the coordination period.) After the 30-month coordination period ends, BCBSM is your secondary plan and Medicare is your primary plan.

End Stage Renal Disease (ESRD) (continued)

Dual Entitlement

If you have dual entitlement to Medicare **and** have employer group health plan benefits, the following conditions apply:

- If entitlement based on ESRD occurs at the same time as or prior to entitlement based on age or disability, the plan provided by the employer group is the primary plan through the end of the 30-month coordination period.

You retired at age 62 and continued your coverage through your employer as a retiree. You start a regular course of dialysis on June 12, 2012, and on Sept. 1, 2012, you become entitled to Medicare because you have ESRD. In February 2013 you become entitled to Medicare because you turn 65. In this situation, even though you turn 65 during the 30-month coordination period, your employer's plan will be your primary plan for the entire 30-month coordination period from Sept. 1, 2012, through February 2015. Your employer's plan will be your secondary plan starting March 1, 2015.

- If entitlement based on ESRD occurs after entitlement based on age or disability, primary plan status is determined as follows:

  – If you are a working aged or working disabled individual in your first month of dual entitlement, the plan provided by your employer group is your primary plan and remains your primary plan through the end of the 30-month coordination period.

You became entitled to Medicare in June 2012, when you were 65 years old. You have coverage through your employer's plan and, because you are still working, your employer's plan is your primary plan. On May 27, 2014, you are diagnosed with ESRD and begin a regular course of dialysis. On Aug. 1, 2014, you become entitled to Medicare because you have ESRD. Your employer's plan remains your primary plan for the 30-month coordination period, from Aug. 1, 2014, through Jan. 31, 2017. Medicare becomes your primary plan on Feb. 1, 2017.

  – If you are not a working aged or working disabled individual in the first month of dual entitlement, Medicare is your primary plan.

You retired at age 62 and continued your coverage through your employer as a retiree. In August 2012, when you turn 65, you become entitled to Medicare. In January 2013, you begin a regular course of dialysis. On April 1, 2013, you become entitled to Medicare because you have ESRD. Because Medicare was already your primary plan when you became dually entitled, Medicare will remain your primary plan both during and after the coordination period.

CANCELLATION

How to Cancel Coverage

Send your written request to cancel coverage to your employer or group. We must receive it from your employer or group within 30 days of the requested cancellation date. Your coverage will then be canceled on the requested date and all benefits under this certificate will end. However, if you are an inpatient at a hospital or facility on the date your coverage ends, please see the General Condition "Services Before Coverage Begins or After Coverage Ends."

Cancellation

We will cancel your coverage if:

- Your group does not qualify for coverage under this certificate
- Your group does not pay its bill on time

If you are responsible for paying all or a portion of the bill then you must pay it on time or your coverage will be cancelled. For example, if you are a retiree or enrolled under COBRA and you pay all or part of your bill directly to BCBSM, we must receive your payment on time.

- You are serving a criminal sentence for defrauding BCBSM
- You no longer qualify to be a member of your group
- Your group changes to a non-BCBSM health plan
- We no longer offer this coverage
- You **misuse** your coverage

  Misuse includes illegal or improper use of your coverage such as:

  – Allowing an ineligible person to use your coverage
  – Requesting payment for services you did not receive

- You fail to repay BCBSM for payments we made for services that were not a benefit under this certificate, subject to your rights under the appeal process.
- You are satisfying a civil judgment in a case involving BCBSM
- You are repaying BCBSM funds you received illegally
- You no longer qualify as a dependent

Cancellation (continued)

Your coverage will end on the last day covered by the last payment made by your group, employer, or remitting agent. However, if you are an inpatient at a hospital or facility on the date your coverage ends, please see the General Condition "Services Before Coverage Begins or After Coverage Ends" in Section 6.

Rescission

We will rescind your coverage if you, your group or someone seeking coverage on your behalf has:

- Performed an act, practice, or omission that constitutes fraud, or
- Made an intentional misrepresentation of material fact to BCBSM or another party, which results in you or a dependent obtaining or retaining coverage with BCBSM or the payment of claims under this or another BCBSM certificate.

Your coverage may be rescinded back to the effective date of your contract after we have provided you with 30 days' prior notice. You will be required to repay BCBSM for its payment for any services you received during this period.

CONTINUATION OF BENEFITS

Consolidated Omnibus Budget Reconciliation Act (COBRA)

COBRA is a federal law that affects most employers with 20 or more employees. It extends the opportunity for continued group coverage to all qualified beneficiaries when such coverage is lost due to a qualifying event. This group continuation option must be selected within 60 days of the qualifying event or the date the COBRA notice is sent by the plan administrator, whichever is later. It provides the following coverage at the covered member's expense:

- 18 months of coverage for an employee who is terminated, other than for gross misconduct, or whose hours are reduced
- 29 months of coverage for all qualified beneficiaries if one member is determined by the Social Security Administration to be disabled at the time of the qualifying event or within 60 days thereafter
- 36 months of coverage for qualified beneficiaries in case of the death of the employee, divorce, legal separation, loss of dependency status, or employee entitlement to Medicare

COBRA coverage can be terminated because:

- The 18, 29 or 36 months of COBRA coverage end
- The required premium is not paid on time

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Continuation of Benefits (continued)

COBRA (continued)

- The employer terminates its group health plan
- The qualified beneficiary becomes entitled to Medicare coverage
- The qualified beneficiary obtains coverage under a group health plan.
- Please contact your employer for more details about COBRA.

Individual Coverage

If you choose not to enroll in COBRA, or if your COBRA coverage period ends, coverage may be available through a BCBSM individual plan. Contact BCBSM Customer Service for information about what plan best meets your needs.